Medication List

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Name:	Address:				
Phone number:					
Date of Birth:					
Emergency Contact/phone:					

Allergies

Allergic to:	Reaction:
Allergic to:	Reaction:
Allergic to:	Reaction:

<u>List ALL medications you are currently taking:</u> please include prescriptions, over-the-counter medications, and herbals. *Update with each visit to your provider.*

Drug Name	Directions: How I take this	I started taking this on:	I stopped taking this on:	Why I take this medication	Doctor's name